Freestanding Nursing Facility, Level-B (FS/NF-B) and Freestanding Subacute Nursing Facility, Freestanding Pediatric Subacute, Level-B (FSSA/NF-B) Quality Assurance Fee – 2011-2012 (FY) Rate Adjustment Payment Invoice for JANUARY 1, 2012 to JULY 31, 2012

Department of Health Care Services
Accounting Section/Cashiers Unit, Mail Stop 1101
1501 Capitol Avenue, Suite 71.2048
P.O. Box 997415
Sacramento, CA 95899-7415

NAME_____

ADDRESS: _____

_____

Office of Statewide Health Planning and Development Number:

_____

National Provider Identifier:

_____

Due Date: DECEMBER 31, 2012

Amount Remitted: $_____

Index	Object Detail	Agency Object	BLK	Source	Agency Source	PCA	FFY	Fund
1650	000	00	H	125600	31	85214	A11	0001

Total Resident Days_____ Multiply by ($0.09 or $0.03 *circle the appropriate rate**) = Amount Due _____

Original Signature _____ Date _____

Print Name _____ Phone Number _____ E-Mail _____

PLEASE SUBMIT THE ENTIRE PAYMENT INVOICE – DO NOT CUT IN HALF

Payment Invoice Instructions:

Total Resident Days: Enter the *Total Resident Days* for the month that is listed on the payment invoice. Resident days are the number of days in which a patient resides at the skilled nursing facility. This includes, but is not limited to Bed Hold Days, Medi-Cal Fee-for-Service, Medi-Cal Managed Care, Medicare, Medicare Advantage, Health Maintenance Organization, Non-Medi-Cal (private pay), Other Insurance, Charity, and Hospice.

Amount Due: * Multiply the *Total Resident Days* by the appropriate rate adjustment amount specified below:

- **For facilities with less than 100,000 total annual resident days, multiply the *Total Resident Days* by $0.09 and enter that amount in the space provided for the *Amount Due*.**
- **For facilities with 100,000 or more total annual resident days, multiply the *Total Resident Days* by $0.03 and enter that amount in the space provided for the *Amount Due*.**

Amount Remitted: Enter the amount of the check or money order you are sending with this payment invoice. This amount should be the same amount as the *Amount Due*.

Original Signature: Sign in the space provided. Please use ink.

Date: Enter the date you completed this payment invoice.

Phone Number/E-Mail: Enter your area code, daytime phone number, and E-Mail address.

Payment invoices are available online at: http://www.dhcs.ca.gov/provgovpart/Pages/QualityAssuranceFee.aspx.

Please submit this completed payment invoice along with the *Amount Due* to the address above. All checks or money orders must be made out to the Department of Health Care Services. Please include the Medi-Cal provider number on the check or money order to expedite the payment process. Payments are due by the date indicated in the due date above. Failure to make the complete payment on time may result in penalties and/or a delay in license renewal.